POPULATION PRIORITIZATION PROCESS 2004

Priority Population Results

Population Prioritization Process 2004

The 2004 Intervention Selection Process

POPULATION PRIORITIZATION PROCESS

PRIORITY POPULATION RESULTS

The Nebraska HIV Care and Prevention Consortium determined the Priority Populations for 2005-2008 at the February 12, 2004 meeting. The top four priority populations are as follows:

POPULATION GROUP IN ORDER OF PRIORITY	POPULATION SUBGROUP
# 1 HIV Positive Persons	Men Who Have Sex With Men (MSM) Female High Risk Heterosexual (HRH) Male High Risk Heterosexual (HRH) (*IDU is included with each subpopulation*)
# 2 Men Who Have Sex With Men (MSM)	African American ages 20-49 Hispanic ages 20-39 Native American ages 20-29 White ages 20-39
# 3 Female High Risk Heterosexual	African American ages 20-49 White ages 20-39 Hispanic ages 20-39 Native American ages 20-29
#4 Female Injecting Drug Users	African American ages 20-49 Native American ages 30-50+
The populations below are not targeted for prevention funding during this cycle. It is recognized that interventions are needed for these groups as part of a comprehensive approach.	
Male Injecting Drug Users	African American ages 20-49 Native American ages 20-29, 40-49 Hispanic ages 20-29 White ages 20-29
Men Who Sex With Men and Inject Drugs	African American ages 20-39 Native American ages 30-49 White ages 20-29 Hispanic ages 30-39 African American less than 19 yrs
Male High Risk Heterosexual	African American ages 20-39 Native American ages 30-39 Hispanic ages 20-39 White ages 20-29

POPULATION PRIORITIZATION PROCESS (2004)

Preparation for the 2005 population priority setting process began three years ago at the Nebraska HIV CARE and Consortium (NHCPC) meeting in October 2001. The following questions provided guidance to the process:

- Does the population priority setting process need to be revisited, revised, and formalized for the 2004 process?
- How should priority populations be categorized? By risk transmission? By sub-populations? By both?
- Should target populations be defined based on behavioral risk/group designations and then expanded with demographic data?
- What variables should be considered?
- Should variables be weighted?
- Should the process be translated into an objective mathematical formula?

This work provided the foundation, which was revised and refined during late 2003 and early 2004, for utilization in developing the 2005-2008 prioritization process. An explanation of that earlier work is included in this comprehensive plan so the reader may understand the depth of the process utilized to attain the current methodology.

It was clear in late 2003, with the introduction of the *Advancing HIV Prevention: New Strategies for a Changing Epidemic* by the Centers for Disease Control (CDC), that there would not be enough dollars for prevention and that there were likely to be fewer in the future. It was also clear that HIV prevention efforts had to be focused on people most at risk, so an additional question was asked during the 2003-2004 prioritization process – How can we prevent the *most* infections?

<u>2001-2002</u>

At the October 2001 meeting, NHCPC members discussed examples of variables (factors) that might be considered when looking at the population priority setting process. Factors discussed were:

- Estimated live HIV cases/estimated live AIDS cases
- Prevalence of predominant risk according to behavioral survey
- Average annual rate of increase in AIDS/HIV incidence in the last “X” years
- HIV incidence by age
- HIV incidence by race/ethnicity as a proportion over the last “X” years
- STD rates
- Relative size of transmission category in the population
- Counseling and testing risk reported prevalence

An ad hoc Priority Populations Committee was created and consisted of 6 NHCPC members; 3 Nebraska Health and Human Services (HSS) staff, including a representative from the Nebraska HIV Surveillance Program; and one volunteer from a community based organization. Composition of the committee included an epidemiologist, an HIV case manager, a prevention sub-grantee, an individual from the AIDS Drug Assistance Program (ADAP), an individual from a city / county health department, an education specialist from Nebraska's largest HIV service provider, the State Community Co-Chair, an individual from the Nebraska HIV Surveillance Program, the State HIV Program Administrator, and an HIV evaluation coordinator.

The first meeting of the Priority Populations Committee, on November 14, 2001, was to:

1) review the CDC guidance, processes, and rationale;
2) look at material, along with samples from the field, which could better prepare the members on how to approach this process;
3) brainstorm potential target populations; and
4) brainstorm all possible factors.

Committee members were provided with the document *HIV Prevention Planning/Setting HIV Prevention Priorities – October 2000* created by the Academy for Educational Development (AED). Members also received copies of priority setting models from a variety of states and cities. The committee adopted the "Seven Steps In Setting Priorities For Target Populations" (*HIV Prevention Planning/Setting HIV Prevention Priorities – October 2000*). For choosing the factors which would be used to set priorities, the members adopted "Guiding Principles For Choosing Factors: North Carolina" (*HIV Prevention Planning/Setting HIV Prevention Priorities – October 2000*).

Committee members generated a list of all potential target populations and all factors that could be used to set priorities for target populations. Each committee member was then tasked with researching data sources for the process of further narrowing the list of target populations and potential factors for priority setting. Members were requested to contact their local planning groups, local/county organizations, individuals, and any other resources they could think of to gather data sources which would be applicable.

At the December 11, 2001 meeting, the list of potential target populations was further structured and refined utilizing a matrix system that aligned the risk behaviors with the categories of men, women, and youth. Numerous data sources were presented and reviewed, ranging from evidence-based sources (i.e. *Nebraska HSS Epi Profile; 1999 Nebraska Youth Risk Behavior Survey; Behavioral Risk Factor Surveillance System – State of Nebraska; Nebraska 2000 STD Statistics*; etc.) to anecdotal data (i.e. regional needs assessment; 2001 Persons Living With AIDS Survey; individual program data; NAF narrative, etc.).

Since Nebraska had not defined factors for setting priorities for target populations in the past, committee members realized that whatever models they looked at, they would have to make them specific to Nebraska. Members completed an NHCPC Priority Setting Process Factors Worksheet modeled after "Worksheet 7: Determine Factors For Target Populations" (*HIV Prevention Community Planning/Setting HIV Prevention Priorities – October 2000*). Factors were listed, definitions assigned to each factor, and data sources aligned to each factor. A smaller sub-committee was formed consisting of 3 members: the epidemiologist, the HIV evaluation coordinator, and the State HIV Program Administrator. Their charge was four-fold:

1) assemble the data for each factor listed by committee members;
2) determine the rating information for each factor;
3) develop a rating scale for each factor; and
4) translate the process into an objective mathematical formula.

The sub-committee met numerous times in December to create a matrix utilizing the exposure risk (MSM, IDU, and Heterosexual) and the sixteen factors/risks associated with transmission of HIV generated by the committee members at the November and December meetings. The 16 factors/risks associated with transmission of HIV were identified as

bisexual sex	sex for survival
HIV positive	youth/age
mental illness	substance abuse
multiple partners	STDs
unprotected sex	race/ethnicity
homelessness	incarceration
women with high risk partners	Men
youth with high risk partners.	Women

This matrix was predicated on the assumption that there are three major transmission methods at greatest risk:

1. blood to blood transmission, primarily seen in injecting drug use
2. anal sex, primarily practiced among MSM
3. vaginal sex, primarily practiced among heterosexuals

(It is noted that these are not absolutes, nor are they intended to be. The factors are those primarily identified by the group.)

The data source was then aligned to the exposure risks and the factors/risks to see if Nebraska had data to support the factors/risks. The sub-committee narrowed down to five (5) factors that could be successfully supported by Nebraska data sources:

1. predominant mode/risk factor
2. AIDS prevalence
3. HIV prevalence
4. barriers to reaching the population/difficulty of meeting population needs
5. emerging trends

Once the five (5) factors were identified, the sub-committee members created the rating information for each factor working with individuals from the Nebraska HSS Surveillance Program to create a rating scale.

Once the sub-committee had decided which factors to consider, they were ready to determine the relative importance (weight) of each factor. Since there is no formula that tells which factors are most important, the sub-committee asked the following questions:

1) How well does this factor demonstrate the prevention needs of the target population?
2) To what extent does the factor focus on a greater risk for HIV infections among the target population? (*HIV Prevention Community Planning/Setting HIV Prevention Priorities – October 2000*).

Using these two questions as a guide, the sub-committee assigned weights to each factor based on how important the majority of the group felt each factor was compared to the other factors. Numeric weights were assigned to each factor on a scale of 1 to 5, with 1 being least important and 5 being the most important. Utilizing the 3 major exposure risk categories (MSM, IDU [which was further broken down into MSM / IDU and Heterosexual IDU], and Heterosexual), the 5 factors, rating information for each factor, rank/scale for each factor, and an assigned weight for each factor, the sub-committee drafted the first cut of the scoring tables – Priority Populations Weight Scale – for discussion purposes with the entire Priority Populations Committee and ultimately the NHCPC group.

On January 7, 2002, the sub-committee presented the draft worksheet "Priority Populations Weight Scale" to the members of the Priority Populations Committee. The members voted to adopt the exposure risk categories, the 5 factors, rating information, and rating scale as presented. Discussion ensued around the factor addressing barriers and members decided to include the following items under barriers for NHCPC members to rate: access, language, isolation, providers, and testing. Members then created definitions for each one of the these items, as it was felt there could be a variety of interpretations for each item and the members wished to provide the NHCPC members with as much clarity as possible. Committee members looked at the proposed weights assigned to each factor and, by a majority vote, decided to adopt the weights as proposed. Upon further review of the draft worksheet, the committee members suggested looking at disproportionate impact for race/ethnicity, gender, and age as factors for setting priorities for target populations. The Priority Populations Committee charged the sub-committee to research Nebraska data sources to find data which would support a methodology to include these factors.

Sub-committee members were further charged to revise the draft worksheet "Priority Populations Weight Scale" to reflect the changes adopted at the committee meeting and to translate the process into an objective mathematical formula.

On January 10, 2002, in trying to address the disproportionate impact based on race/ethnicity, sub-committee members once again reviewed models from the field, specifically Pennsylvania's "Priority Setting Model for Pennsylvania (excluding Philadelphia) HIV / AIDS Prevention Planning". Borrowing from Pennsylvania's model, but making it specific to Nebraska, sub-committee members created a 6th factor identified as "race/ethnicity as proportion of HIV incidence in 1996-2000" and created rating information and a rank/scale for this factor. Sub-committee members felt that a separate "Priority Populations Weight Scale" could easily be completed for both male and female, thus addressing the gender issue. In looking at age, according to the HIV/AIDS Surveillance Report through June 2001, the AIDS total for ages 19 and younger was 16 and the HIV total for the same age group was 21. This data did not substantiate youth as being a factor for setting priority populations. However, data in the 20-29 age range did substantiate taking a closer look at age, as statistically about 1/3 of the 20-29 year olds were impacted by the HIV diagnosis and the increases in numbers over the years were significant enough to point to teenage exposure. Sub-committee members also felt youth and young people were at high risk of contracting HIV due to their engagement in risky behaviors. Sub-committee members researched data sources and created a Multiple High-Risk Behaviors matrix that addressed STD, substance use, and multiple partners. These three factors were broken down into gender (male and female) and the following age groups: 13-19 years old, 20-29 years old, and 30+ years old. Each group was given a rank/scale and data sources were researched to support the factors in the corresponding gender and age categories. Sub-committee members felt this tool could be utilized for allocating resources after the priority populations had been identified.

Sub-committee members met with Nebraska HIV Surveillance Program staff to further align data sources to support the 6 factors. Surveillance staff provided sub-committee members with HIV percentages within each transmission category for race/ethnicity as proportion of HIV incidence in 1996-2000. Surveillance staff also provided data for HIV and AIDS within each transmission category for each factor. Once this data was aligned it was included in the revised "Priority Populations Weighting Scale" and sub-committee members then created an objective mathematical formula to utilize in setting the priority populations.

On January 7, 2002, sub-committee members met with the rest of the members of the Priority Populations Committee and presented the revised draft of the Priority Populations Weighting Scale with race/ethnicity and gender included along with the mathematical formula. Committee members tested the draft Priority Populations Weighting Scale using the mathematical formula to further assess whether it would be applicable to the NHCPC. Committee members voted to accept the revised draft as the working tool to be submitted to the NHCPC at the January 23-24, 2002 meeting. Due to the importance of prioritizing populations for resource allocation, members of the Priority Populations Committee agreed that a democratic process of all NHCPC members must decide the process of weighting the factors and assigning levels of effect (ranking/scoring factors for each transmission category). Upon completing the testing of the Priority Populations Weighting Scale, members approved the final draft of the Priority Populations Weighting Scale. This then became the tool for deciding priority populations for the state of Nebraska. Committee members refined the definitions to the Priority Populations Weighting Scale and created directions on how to use the tool. This document was added to the Priority Populations Weighting Scale to offer further clarity to the NHCPC members.

The Priority Populations Weighting Scale was presented and explained to the larger NHCPC body at their meeting on January 23, 2002 for review and discussion. Once exhaustive discussion was completed, the NHCPC members voted to approve the tool "Priority Populations Weighting Scale" for the process of setting priority populations. They then set about the task of weighting each factor's relative importance in prioritizing populations and ranking the effect of each factor on the transmission risk groups (target populations) with assistance from the Priority Populations Committee members. Utilizing the mathematical formula, the scores from all factors were added, producing an overall score for that transmission risk group (target Population). This overall score reflected the combined impact of all factors used to rate that transmission category / target population. The NHCPC rank-ordered that target population in order of their overall scores, from highest to lowest. The target population with the highest overall score ranked #1, the second highest score was ranked #2, etc. The NHCPC then reviewed their ranking and developed the final list of prioritized target populations for Nebraska.

As the committee and NHCPC were working with the Priority Population Weighting Scale tool, at least one weakness with the tool was identified. It was discovered that the tool did not strongly factor in the disproportionate impact related to race and ethnicity.

For 2003-2004 funding, to ensure the important factors of race/ethnicity and age were fully considered, NHCPC elected to designate up to one third of the HE/RR funds to projects delineated to minority populations and up to one third to youth within the priority populations.

2003-2004

Work on the priority population prioritization process was picked up again in early 2003 in preparation for a new Comprehensive Plan and grant period. Timelines originally called for priority populations to be determined at the October 2003 NHCPC meeting in order to give ample time to the interventions committee for their work. With the introduction by CDC of the new Community Planning Guidance and the *Advancing HIV Prevention* initiative in late summer, timelines were revised to allow staff and NHCPC members time to incorporate the new guidelines and principles. It was decided to create a comprehensive plan that would span 2005 through 2008 to coincide with the new five-year CDC Cooperative Agreement.

As a part of the new *HIV Prevention Community Planning Guidance*, CDC included the following attributes related to defining priority populations for the jurisdiction:

6. Evidence that the size of the at-risk populations was considered in setting priorities for target populations.
7. Evidence that a measurement of the percentage of HIV morbidity (i.e., HIV incidence or prevalence), if available, was considered in setting priorities for target populations.
8. Evidence that the prevalence of risky behaviors in the population was considered in setting priorities for target populations.
9. Target populations are defined by transmission risk, gender, age, race/ethnicity, HIV status and geographic location.

- Target populations are rank-ordered by priority, in terms of their contributions to new HIV infections.

At the July 24, 2003 NHCPC meeting, HHS surveillance staff presented updated epi information to the group complete with graphs and statistics. In the discussion of the approach to population prioritization, it was decided by the group that the prior process was valid with the exception of effectively incorporating age and race/ethnicity factors. Since the changes needed were related primarily to determining how to best statistically approach this challenge, a small group consisting of surveillance staff, HIV program staff and the NHCPC epidemiologist was tasked to design the mechanics of this process for presentation at the October meeting. This timeframe was later revised to delay the final process until the January 2004 meeting.

The following table was used to define the behavioral risk groups as well as who is and is not included in each group.

POPULATION DESCRIPTIONS

POPULATION	DESCRIPTION	THIS INCLUDES…	THIS DOES NOT INCLUDE…
Individuals with HIV infections may fall into any of below categories and are at risk of transmitting HIV through any of the behaviorally defined modes below (excluding General Population)			
MSM Men who have sex with men	Men of any age or race who participate in unprotected oral and anal sex with other men. Within MSM there are gay, bisexual, non-gay or bisexual identified MSM and those who identify as transgender.	• Young MSM (YMSM) • Men of color who have sex with men • Urban MSM • Rural MSM	• Men who have sex with men AND inject drugs (MSM/IDU)
IDU Injection drug users	People of any age or gender who inject any substances into a vein or muscle, or through "skin popping" and share the needles and/or other injection equipment.	• Individuals who inject substances and have partners of the opposite sex • Individuals who inject substances and are women who have sex with women	• Non-injection substance abusers • Individuals who do not inject substances themselves, but who have sex with individuals who do inject (Heterosexual risk or MSM) • Men who have sex with men and inject substances (MSM/IDU)
MSM/IDU Men who have sex with **m**en AND inject drugs	Men of any age and race/ethnicity who have sex with other men AND who inject any substance into a vein or muscle or through "skin-popping", and share the needles or equipment and/or other injection equipment.	• Only those men who have sex with other men AND inject any substance	• Men who EITHER have sex with other men (MSM) OR inject any substance (IDU)
HRH High Risk Heterosexual	Individuals of any race/ethnicity or sex who have unprotected oral, anal or vaginal sex with a person of the opposite sex who is at increased risk for HIV infection.	• Individuals whose partner of the opposite sex has HIV, injects substances, or is a man who has sex with other men • Individuals who have sex while drunk or high • Individuals with a sexually transmitted infection • Individuals who trade sex or pay for sex with drugs, money, food, shelter, etc. • Individuals who have been forced to have sex	• Individuals whose only risk is being sexually active or have multiple partners (General Population) • Individuals who acknowledge MSM and/or IDU risk (have separate categories)
General Population	Individuals who do not report risks that are included in the above populations		Individuals who report any risks included in any of the above populations.

*CDC definition: Youth in high-risk situations are aged 10-24. These youth include, but are not limited to: youth who have run away or are homeless; are not in school and are unemployed; seek treatment for substance abuse, especially for injecting drugs and using crack cocaine; are juvenile offenders; are medically indigent; require mental health services; are in foster homes; are migrants; are gay and lesbians; have had sexually transmitted diseases, especially genital ulcer disease; have been psychologically, physically, or sexually abused; are pregnant; seek counseling and testing for HIV infection; exhibit signs or symptoms of AIDS or HIV infection without alternative diagnosis; barter or sell sex; are in alternative or continuation schools; are in gangs.

Following the table is CDC's definition of youth a as reminder of who is and is not included when "youth" are addressed. To ensure gender representation, it was decided to further divide the injection drug use (IDU) and high risk heterosexual (HRH) into male and female groups

Through a series of meetings from July through November of 2003, the process and mathematical formulas were modified to ensure improved flow of information and scoring processes and to ensure a stronger objective format for including race/ethnicity, age and gender factors. Instead of having one large Weight/Rank Score Sheet (+6) that encompassed all the behavioral risk groups, a separate sheet was developed for each population to be ranked: MSM, MSM-IDU, Male IDU, Female IDU, Male HRH and Female HRH. The factors and weights did not change.

A Race/Ethnicity and Age Factors Score Sheet (Attachment #9) was developed for each of the behavioral risk groups which integrated a ranking scale for HIV/AIDS rates and a ranking scale for Other Risk factors (such as STD rates, high use of Counseling and Testing, drug and alcohol abuse, and multiple partners) with race/ethnicity by age. The rating scale for each factor was defined but the weight for each factor was determined by the NHCPC members. The Other Risk Factors, with the exception of Counseling and Testing use data, had been identified in the prior process.

This process and the worksheets were presented to the NHCPC at the February 2004 meeting. After explaining the process, the rationale for the changes, and determination by the group of the weights for the identified factors, the group was led step by step through the process. To facilitate the process, the members were divided into six groups with an assigned staff liaison. Each group was responsible for scoring one of the six risk groups. Step one involved completing the Priority Population Weight/Rank Score Sheet. Any objective data that could be supplied was included on the worksheet to save time. Each group had to assess the barriers section which considered the questions of access, language, isolation, providers and testing. Each of these areas was part of the 2002 process and was supported by specific definitions. This resulted in a total score for each risk population. Step two allowed for factoring in of HIV and AIDS risk data as well as other surrogate data for related risk markers. The surrogate data considered included:

- Sexually transmitted diseases of chlamydia and gonorrhea as markers for sexual behavior
- Drug and alcohol abuse data as the marker for related behaviors shown to directly relate to engaging in higher risk sexual behaviors
- Limited data regarding multiple sex partners as a marker for increased transmission by virtue of repeated exposures with partners of potential positive or unknown status
- Counseling and testing site use data as a marker for identifying who is concerned about sexual and/or needle sharing risk behaviors by virtue of their need and/or desire to test

Most of this data was available broken down by sex, race/ethnicity and age. Groups were asked to review this key STD data, substance abuse data, behavioral risk factor survey data and counseling and testing data to determine the number of these factors that applied to the risk population by race/ethnicity and age. The HIV and AIDS data was converted to a rate per 100,000 for the race/ethnicity and age group and provided to allow comparability and ranking. This was further supported by general data tables of HIV/AIDS data. When completed, this worksheet provided a score for each behavioral risk group by race/ethnicity by age group. The group was asked to then circle the top six scores on this sheet and transfer it to the Population Summary Sheet (Attachment #10), which essentially serve to identify the subpopulation risk groups by race/ethnicity and age group.

To complete the process, scores from the Weight/Rank Score Sheets and the Race/Ethnicity and Age Factor Score Sheets were transferred to the Final Score Summary Sheet (Attachment #11) for final analysis. The Weight/Rank score for each population was used to determine the order of priority for the HIV positive subgroups as the data for this worksheet was based primarily on existing positives in Nebraska. Age and race/ethnicity factors were not considered in these subgroups due to the small actual numbers involved which could easily preclude the ability of any agency to mount an effective intervention effort if limited in this way.

The combination of the score above with the six top Race/Ethnicity and Age Factors scores for each risk population provided the score upon which the priority of non-positive populations were based. As a large group, all numbers were reviewed and discussed. It was determined that three additional populations would be targeted in addition to HIV positive. Within each of the top three populations, Race/Ethnicity and Age factors were further combined as appropriate to define the target subpopulations. A discussion about “real numbers” of persons reachable in specific populations led to the decision to make some further minor revisions prior to the final list.

Although four priority populations were identified along with their subgroups, the membership determined all the populations should appear in the comprehensive plan along with recommendations for interventions. This would provide a blueprint for future funding and/or identification of gaps for other groups who may want to fund HIV related activities.

Once the populations and subpopulations were determined, the Intervention Committee was charged to develop interventions matched to the identified populations.

THE 2004 INTERVENTION SELECTION PROCESS

Selection Process Summary

Apirl 2003 NHCPC Meeting

During the regular committee meeting time, the Intervention Committee began discussing and laying out the process they would use to identify appropriate interventions to be used in conjunction with the 2005-2006 Request for Applications (RFA). While final selections for priority populations had not yet been made by the NHCPC membership, the Intervention Committee decided to focus on the population groups previously prioritized for the 2003-2004 grant years. This was supported by current epi data for Nebraska.

Each member of the Committee was tasked with researching resources for the process of selecting interventions. Members were encouraged to contact their local planning groups, local organizations, individuals, and any other resources they could think of to start gathering data on possible interventions that could be successfully implemented in Nebraska. The members were asked to bring this information to the October 2003 NHCPC meeting for further discussion and review.

The Committee identified several action steps to be completed prior to the October 2003 meeting:

- Request that each priority population identified by the NHCPC be broken down by age/race
- Facilitate a discussion with the NCHPC membership regarding the degree of specificity of recommended interventions
- Request assistance from the Public Information Committee in publicizing the 2005-2006 RFA
- Send surveys out to regional representatives to gather additional information on the epidemic at the local level

October 2003 NHCPC Meeting

During the regular Committee Meeting time, members reviewed information on characteristics of successful interventions. The committee chair led a discussion on the steps to follow for the intervention selection process. This included a worksheet designed to identify population-specific issues to consider when selecting interventions, including available resources, gaps in services, societal norms, etc.

The State Liaison also led a discussion with the general NHCPC membership to gather input on how specific the identified interventions should be. Recommendations were to identify specific interventions for inclusion in the RFP. The concensus was that this would aid in the provision of capacity building at the agency level and would insure that all funded interventions are based on behavioral and social science, outcome effectiveness, and will have been adequately tested with intended consumers for cultural appropriateness, relevance, and acceptability.

Prior to the February 2004 meeting, the State Liaison conducted additional research on the Internet and in-house resources to identify interventions that have been documented to be effective in preventing HIV infection in targeted populations. The main resources utilized were:

- Compendium of HIV Prevention Interventions with Evidence of Effectiveness (CDC 1999)
- CDC's Replicating Effective Programs
- Center for AIDS Prevention Studies (CAPS) Model Prevention Programs
- The Diffusion of Effective Behavioral Interventions project (DEBI)

The State Liaison put information packets together for each risk population that included information about the interventions that targeted that specific population.

February 2004 Intervention Committee Meeting

During the regular committee meeting time, committee members reviewed the contents of the information packets provided by the State Liaison. Each Committee member was assigned a risk population and given the appropriate information package. Utilizing the risk population worksheet they received in October and the information in the packets, Committee members were to put together a suggested list of possible interventions for their assigned risk population.

It was determined that a special, one-day working meeting was needed to review and score the interventions identified for each risk population. This meeting was scheduled for March 12, 2004, in Lincoln.

During the regular February NHCPC meeting, the general membership selected the priority populations for 2005.

Prior to the work meeting, the State Liaison and the Committee Chair met in Lincoln to finalize the process the Committee would use to score the interventions. The process included the identification and weighting of factors to consider when scoring the interventions. User-friendly worksheets were developed to facilitate the process (Attachment #12).

March 2004 Work Meeting

The Intervention Committee held an all-day work meeting to review the interventions they had identified for their assigned risk population. At this meeting, the committee members first identified and agreed upon a set of factors to score each intervention on. These factors were high priority, efficacy and effectiveness, practicality, appropriateness, ability to evaluate and contributing issues addressed. These factors were each assigned a weight based on their perceived importance. The interventions were scored on each of the factors, the sum of which became the intervention's overall score.

April 2004 NHCPC Meeting

During the regular committee meeting, committee members reviewed all of the interventions that were scored. A discussion followed on how many interventions should be recommended for each of the priority populations. Factors considered included the challenges faced in reaching specific risk populations and the capacity-building needs of the community to provide services. Recommendations were finalized for a final slate of interventions to be presented to the NHCPC general membership at the June 2004 meeting.

June 2004 NHCPC Meeting

The Committee Chair gave a presentation to the NHCPC membership to explain the process the Committee had used to arrive at the final slate of interventions being recommended. This included a short description of each intervention, the behavior theory it was based on, and the evaluation process utilized to document effectiveness.

The NHCPC membership voted to approve the recommended slate of interventions. These interventions will be incorporated into the 2004-2005 Request for Applications (RFA). Following is a complete list of these interventions:

Priority Populations	Population Subgroups	Interventions
#1 HIV positive Persons	♦ Men Who Have Sex with Men (MSM) ♦ Female High-Risk Heterosexual (HRH) ♦ Male High-Risk Heterosexual (HRH) (IDU is included within each population)	♦ Prevention Case Management (PCM) ♦ Healthy Relationships ♦ Holistic Harm Reduction Program ♦ Mpowerment
#2 MSM	♦ African Americans ages 20-49 ♦ Hispanics ages 20-39 ♦ American Indians ages 20-29 ♦ Whites ages 20-39	♦ Prevention Case Management (PCM) ♦ Mpowerment ♦ Community Promise ♦ Internet Outreach ♦ Many Men, Many Voices
#3 Female HRH	♦ African Americans ages 20-49 ♦ Whites ages 20-29 ♦ Hispanics ages 20-39 ♦ American Indians ages 20-29	♦ Real AIDS Prevention Project ♦ Community Promise ♦ Sista Sista ♦ Voices/Voces
#4 Female IDU	♦ African Americans ages 20-49 ♦ American Indians ages 20-50+	♦ Community Promise ♦ Popular Opinion Leader

Counseling and Testing and Partner Counseling and Referral Services Interventions apply to all populations. A specific theoretical model, described below, supported each intervention.

HIV POSITIVE

Interventions:

- *Prevention Cast Management – individual-level intervention based on Social Cognitive and Stages of Change theories.*
- *Holistic Harm Reduction Program – group-level intervention based on Information, Motivation and Behavior (IBM) Model of Behavior Change.*
- *Healthy Relationships – small-group intervention based on Social Cognitive Theory.*
- *Mpowerment – formal and informal outreach, peer-led small groups, and social marketing intervention(s) based on the Diffusion of Innovations and Peer Influence theories.*

MEN WHO HAVE SEX WITH MEN (MSM)

Interventions:

- *Prevention Case Management – individual, client-centered prevention activity based on the Social Cognitive and Stages of Change theories.*
- *Mpowerment – formal and informal outreach, peer-ed small groups, and social marketing intervention(s) based on the Diffusion of Innovations and Peer Influence theories.*
- *Community Promise – community-level intervention based on the Stages of Change, Reasoned Action, and Social Cognitive theories.*
- *Internet Outreach – individual-level intervention based on the Stages of Change Theory.*

HETEROSEXUAL FEMALE AT HIGH RISK

Interventions:

- *Real AIDS Prevention Project – individual-, group- and community-level intervention based on the Stages of Change Theory.*
- *Community Promise – community-level intervention based on Stages of Change, Reasoned Action, and Social Cognitive theories.*
- *Sista Sista – group-level intervention based on Social Cognitive Theory.*
- *Voices/Voces – group-level intervention based on the Theory of Reasoned Action.*

FEMALE IDU

Interventions:

- *Community Promise – a community-level intervention based on Stages of Change, Reasoned Action, and Social Cognitive theories.*
- *Popular Opinion Leader – community-level intervention based on the Diffusion of Innovations and Social Cognitive theories.*

Three additional risk populations were identified by the NHCPC as being at risk for HIV infection, but not prioritized for funding for the 2005-2006 funding periods. These risk populations included Male IDU, MSM IDU, and Male High-Risk heterosexuals. The Intervention Committee also reviewed and scored interventions for these populations so that recommendations would be readily available should additional funding opportunities be identified. Results are as follows:

MALE IDU

Interventions included Prevention Case Management, NIDA Community Outreach, Safety Counts, Community Promise, and Popular Opinion Leader.

MSM IDU

Interventions included Prevention Case Management, Community Promise, Popular Opinion Leader, Safety County, and NIDA Community Outreach.

HIGH-RISK MALES

Interventions included Community Promise, Popular Opinion Leader, and Voices/Voces.

In addition to the interventions by priority population based in theoretical models, compendium interventions, DEBI's, and replication models, an underlying intervention for all groups centers around Counseling and Testing. CDC Procedural Guidance serves as the program model for Counseling and Testing, as well as Partner Counseling and Referral Services. These services will be targeted to all identified risk populations.

Interventions that fall under Health Communication and Public Information include ongoing support of a statewide hotline. Additional interventions are defined annually by the NHPCC Public Information Committee based on identified needs. The ongoing "mini-grant" process, as well as internal funding, will support these efforts.